DATE: September 13th, 2007 PLACE: Mansfield Health Education Center

PRESENT: Billings/St. Vincent Healthcare (SVH): PClifton, SHageman, TCoble; Billings/Billings Clinic(BC): BVonbergen, BHurdMD ; ESchuchard(Glasgow), KTodd(State); CThompson(PHTN) MRaile (Lame Deer);'CGoffena/MSU Nursing student; JHansen (CIT). TBarker, RMartin (both Livingston)

5 Facilities/10 persons
TELEPRESENT: CMintz, GMintz, MJohnson (Terry); HNiehaus(Glendive); DKarsten(Circle); LLeibrand, Chip Fosland, MFarber (Scobey); RFilbin(Red Lodge); PTurnbaugh, NBrown(Poplar); DThompson, LBerg, SMitchell (Harlowton); CBrown, BFrench, TMoore(Culbertson); LBieshevul (Broadus); STaylor(Miles City); DAnderson, CMehl, BJohnson(Plentywood); KRonneberg(Big Timber); KPeden(Chair, from Georgia);
12 Facilities/ 24 persons telepresent

Total: 17 facilities/36 persons THANK YOU!!

TOPIC	DISCUSSION	RECOMMENDATION	ACTION / FOLLOW-UP RESPONSIBLE PARTY
CALL TO ORDER	Meeting was called to order at 1530		
REVIEW OF MINUTES	P Clifton will amend March minutes to reflect that L Matrenga and K Ronneberg went to Red Lodge MHA CEO meeting on K Peden's behalf.	*Call facilities where names are unclear in roll call and get them accurately into the record* *After the meeting, K Todd recommended that a certificate of attendance be granted to each person/facility so as to represent their regional involvement for designation purposes*	**P Clifton will make minutes changes** **P Clifton and B VonBergen will design the certificate**
EDUCATION AND CASE STUDIES (presentation was staggered due to speaker availabilities but is combined in the minutes)	CASE #1: MVC rollover, difficult extrication; initial report underestimated severity of brain injury. EMS crew required assistance to navigate rural road efficiently and rural crew team work was integral in their travel time; TEAM course preparation resulted in accurate field assessment of GCS and injury severity which triggered trauma team (and provider who was off duty came in!!), with rapid airway intervention and transfer call. Blood was requested from a area hospital and brought by Montana Highway Patrol. Patient got to definitive care quickly and had a stable course without complications	*Utilization of TEAM course initiatives and an administratively supported trauma team plan in a critical access facility saved this life. There was no hesitancy in securing airway despite provider and facility having limited airway experience. Airway was successfully managed and ATLS patterned resuscitation initiated. Recommended we establish patient and rehab link and track his progress over time.*	**B VonBergen to work on long term follow up as a systems effectiveness example.**

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	CASE #2 : 3 person helicopter crash called in by a farmer with a delay created by the lack of area cell phone coverage. Challenges faced in landing without on-site guidance, power lines, active fire, exposed patients all discussed. Triage decisions clarified and care of patient who was transported by air discussed with relevant radiographs presented.	*Scene safety is ultimate responsibility of pilot and crew but there is much first responders and others can do to optimize landing: accurate directions, alerts to hazards, shielding patients from rotor wash.*	**Informational**
	CASE #4 30 yr old female, intimate partner violence, boot-kicked in the perineum and hemorrhaging vigorously upon presentation to a critical access facility who could not give her blood. Their transfer call was timely and their assessment and care accurate. There was only one aircraft available in a timely fashion to get her and they were out on a call. The provider with the patient had to, by his own documented count, make 6 phone calls (3 to the regional facility and 3 to the area facility) to implement this transfer. The patient left his facility by ground 1 hr after arrival and was taken to an area facility closer to the regional facility, given blood and fluid and retrieved by air services 45 minutes after that. She had no negative outcome. This topic was also presented later in the meeting as an Open Forum request to the sites to identify their transfer challenges. All comments contained here.	*Multiple facilities spoke up that this is an ongoing problem for them as well. A surgical trauma patient isn't as hard to transfer as a medical patient but it does happen that they are told, when they call, that they are to make the contact with the accepting physician themselves. It is the opinion of the committee that it is unacceptable for the provider in a rural facility with limited resources and manpower to be diverted from patient care in order to coordinate the transfer. However, in order for the handoff of the responsibility for transfer to be eased, an accurate, thorough and rapid relay of patient information needs to occur, as well.* *This is a historically consistent regional concern. The regional facilities espouse the "one call does it all" principle but it is not born out in reality. 3 facilities validated this experience. ED MD is authorized to accept a trauma patient but that may*	**Providers and their administrators are asked to write to the administration at the regional centers, as well as place timely calls to the coordinators, whenever they feel they are less than supported in their transfer requests.** **B VonBergen and P Clifton will, with their Trauma Medical Directors, address this issue with their emergency department providers and investigate the mechanics of a transfer call and any**

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		not be true for medical patients.	**related barriers.**
		The availability of all air services in a region and their known ETA should be readily visible and available to ED physicians taking phone calls so that there is not time taken to investigate availabilities.	**P Clifton and B VonBergen will work with both regional communication centers and investigate the current sharing of information and how it can better be displayed or relayed. P Clifton has sent this through internal review processes at SVH already.**
		A 1:5 NS: H202 kerlix roll packed into a wound such as this, and secured with aces or a pelvic wrap, can provide hemorrhage control per Dr.Hurd. Dr. Peden advises that sedation may have been needed to pack this wound.	
		J Hansen noted that Big Timber is doing 3-4 ground transfers/week because of lack of air transport ability.	**P Clifton will send out the current version of the SVH SBAR MD to MD communication form. Facilities may consider building a similar record for themselves to track the relay of information and document the guidance they are given.**
		There was discussion that the best method of transport for this patient may have been by ground all the way. A regional blood plan including universal donor blood that could be made available to a patient such as this en route to definitive care. There was a single comment about whether the facility dispensing the blood has any responsibility to see the patient as they stop en route. Montana Highway Patrol has brought blood from one facility to another.	**Facilities without blood capacity may consider agreements with blood**

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		The trauma coordinator at the transferring facility has worked with her administration about blood expanders since blood on site at her facility is not an option.	**banked facilities to have blood transported by MHP**
	CASE #3 : 15 yr old female rollover without ejection. Severe pelvic fracture. Taken to an area hospital where the mid-level provider had recently completed ATLS. Patient got timely large bore access and rapid pelvic wrapping and transfer request. She was stable upon arrival at regional care and kept her binder for 3 days after which she went for ORIF and then rehab. She has had longstanding orthopedic challenges despite her optimal management at the area hospital.	*Pelvic binding, in this case, prevented hemorrhage and likely staved off intra-abdominal compartment syndrome and other complications that result from pelvic trauma and shock.*	**Informational** **K Todd asked N Brown and P Turnbaugh (Poplar and Wolf Point) to approach T Stand about presenting a case at next ERTAC.**
STATE REPORT	Kevin Fitzgerald: new EMS System Manger; will be responsible for developing and implementing an EMS system in the state. Very glad to have him. Only one facility left in the state still in need of state designation consultation. All are progressing rapidly towards trauma center development towards designation ■ Regional Trauma Centers ■ Billings (2) ■ Missoula (2) ■ Great Falls ■ Community Trauma Facility ■ Livingston ■ Trauma Receiving Facility ■ Big Timber ■ Chester ■ Harlowton	*None*	**Informational**

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	Air Medicine: See Prehospital Subcommittee notes below. Mid-Level Trauma Course: very successful in western region with hands-on trauma skills training for FNP and PA-C. Would like to repeat in Eastern region Spring 2008. Disaster preparedness: Contact J Nemec at State if interested in the Regional Assistance/DMAT planning with Idaho and/or Disaster Life Support classes		
GENERAL MEETING	New Leadership: Dr. Peden tenure ends in December; Dr. Mike Wilcox is interested and needs HIS clearance. Nominations were requested from the tele sites. None were forthcoming. Dr. Ole of Red Lodge has been suggested in the past. 2 yr tenure. Meeting format: All agree that case studies leading the meeting and then housekeeping and update items at end or on paper are more interesting than past methods. Website will be helpful in the future for sharing information and communicating about meetings. A suggestion was made that the force of the committee be brought to bear to support one subcommittee at a time and get it up and running as the IP and EMS committees aren't active. B VonBergen was Billings Clinic injury prevention and is now their Trauma Coordinator but can provide insight to this subcommittee. The SVH IP coordinator who left MT in May 2007 did not provide any handoff of projects or plans with the IP Subcommittee she was building, so there is much work to do. Another suggestion was made to hold off on IP until these roles are filled, but the regional feeling was that there is work that can be done in the meantime. A specific request was made by Harlo for the State to deliver again the injury prevention meeting.	*Leadership should be by nomination and regional vote; Vice-Chair position creation would allow grooming of next leader. Tele sites may not feel as comfortable speaking their suggestions on line.* *K Todd responded to the request from Harlowton. The injury prevention meeting was held to bring together injury prevention stakeholders to develop common goals by Bobbi Perkins, the State Injury Prevention Coordinator. K Todd will share the interest in another meeting with B Perkins.*	**P Clifton and B VonBergen will design a post ERTAC eval form where suggestions are solicited and send out after each meeting.** **P Clifton will send contact information for Dr. Ole to Dr. Peden** **P Clifton and B VonBergen to design the nomination and voting process and present to committee.**

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	Regional Trauma Plan: Dr. Peden suggests that all subcommittees develop formats to meet in regular and meaningful fashions and that projects all be a part of a regional trauma plan and updates provided at general session. P Clifton mentioned that teleconferences via phone are an inexpensive way to meet without travel . The State contact list under development could be used to build email groups for communication by subcommittees at no expense as well. Having goals and objectives, regular meeting times, assigned tasks and good methods of communicating that meld with personal schedules is essential for subcommittee success.		
	Education Subcomm: 1. TEAM: revisions continue to be made even after recent deployment as part of bioterrorism grant. Content and format changes needed still. Cannot be delivered until completed. Course is recommended by State site surveyors. There are currently 5 sites on waiting list: Ekalaka, Baker, Broadus, Harlowton. Requests for course information and scheduling go to E Schuchard. K Todd says she and J Nemec should have it done by Christmas. There is monetary support for the near future from the bioterrorism grant but it isn't permanent. CME and CEU have been not only expensive but time consuming and will likely no longer be attached unless other plans can be made, especially with Bioterrorism grant monies ending. 2. TNCC: material is new for 2006 so old instructors must be updated and tested before new instructors can be trained. $1200 being donated by ERTAC towards materials needed to deliver this popular ENA trauma nurse course. Materials arriving 10/1/07		**P Clifton and B Von Bergen need to notify trauma surgeons and ED doctors that their help will be needed at these courses and have them share availability with E Schuchard. Then those times are sent to the requesting facility.** **P Clifton to find out from NWREI, the CME vendor, why the delivery of the same course in the same format on a repeated basis has an individual CME charge each time**.

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	TNCC Provider courses: 10/30-31/07 Billings /BC (Rahm) 10/29-30/07 Glasgow (Schuchard) 11/8-9/07 Sidney (Schuchard) 11/13-14/07 Culbertson (Schuchard) 11/15-16/07 Circle (Schuchard) 11/26-27/07 Wolf Point (Schuchard) 11/28-29/07 Poplar (Schuchard) 1/08 Billings/ SVH (Clifton) 3/08 Billings /BC (Rahm) 10/08 Billings/ BC (Rahm) (BC = Billings Clinic SVH = St. Vincent Healthcare) Instructor Update: 10/8 or 10/12/07 Billings/ BC (Rahm) 10/17/07 Glasgow (Schuchard) 1/11/08 Great Falls (Schuchard) New Instructor Course 10/16/07 Glasgow (Schuchard) 11/2/07 Billings/BC (Rahm)		
	3. PHTLS: Prehospital Trauma Life Support Class. A curriculum update was also made available on this course recently but many Eastern Montana instructors still need it. Kevin Fitzgerald, new to leading EMS at State, will provide oversight and future coordination. Next course is 10/27-28 in Glasgow (Schuchard)	*K Todd followed up with Dave Gurchiek on the plan to update PHTLS instructors in the ERTAC and he plans on doing this in May in coordination with the MT EMS Symposium.*	
	4.ATLS: Courses for 2007 are full. 2008 is filling up. See MontanaEMS website for 2008 dates. Each course needs 4 EMT and 4RN to staff and has 4 auditor slots (150$ to audit). Call Gail Hatch at 444-3746 to sign up to take, staff, or audit a course. A 5th course may be planned for Kalispell next year as demand is so high. A new instructor course is planned.		

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	ATLS Provider Courses 2/29 and 3/1/08 4/11-12/08 Billings 6/6-7/08 11/7-8/08 Billings		
	5. Rocky Mountain Trauma Symposium 9/11-12/2008 in Missoula with Systems Pre-conference 9/10/08. ERTAC sponsorships are available. Contact Schuchard. A		
	6. PDA STAT man: ERTAC has a simulator who can be run from scenarios built on a laptop and uploaded into a palm pilot. Scenarios need to be built. By next meeting a plan will be developed to facilitate this so that mannequin can be made available for rural training on a request basis.	*Consider contracting with individual(s) to* *1. become expert in the machine* *2. build a set number of trauma related scenarios into the laptop* *3. test drive the PDA/mannequin mode* *4. Develop the contracts for regional use and a plan for replacement parts.*	**S Taylor may consider contact SV Foundation and MT Health Network. Draft a proposal for funding request and send to E Schuchard for approval and funds dispersement.**
	5. Education Funding request: Miles City requested funding support for a PHTLS course. They have funds to contribute and would like assistance from ERTAC monies. There are current texts that can be borrowed from state to offset materials costs.	*The request is consistent with ERTAC funding goals and is approved for $500. It is recommended that S Taylor approach both the St. Vincent Foundation and Kylene at MT Help Network for funding partnerships as well.*	
	6. Website development: Dr. Peden gave a 6 month time frame for website development. We have met over this at the May ERTAC and again via email and at Systems Conference. J Detienne at EMS/Trauma Systems would like the page to be complete prior to going "live." In the meantime, a sign up sheet was circulated at Systems conference so state can regional contact lists for the website.	*Complete the contact list from the Systems conference and place on website for validation, additions, and updates ASAP.*	**State to coordinate a conference call between the three trauma regions to discuss and agree upon website options.**

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	<u>PreHospital Subcom:</u> 1. Confusion since last meeting regarding membership, expectations, and leadership. Chris Mehl has already built a functional EMS directors group for the Eastern Region which is very active. 2. K Todd reported that Air Medicine in Montana will be addressed in the coming year, issues like helicopter dispatch guidelines, trauma flight protocols, and patient packaging will be addressed. The flight teams will meet first together with the State. It was suggested that this subcommittee might be a vehicle for follow-up of these issues. <u>Injury Prevention (see above discussion)</u>: P Clifton shared that falls were addressed at RMRTS in Great Falls last week as an accelerating cause of home injuries especially in the elderly and if anticoagulated. Reduced Time to CT and Time to FFP are linked to markedly improved outcomes in recent literature. There are implications for regional planning in MT at all points of patient contact. This would be a good subcommittee project. We also need to gear up for the next legislative session to push again for primary seat belt law.	*This could serve as the infrastructure for ERTAC Prehospital Subcom. Dwight Thompson, recently awarded a Masters Degree in EMS, would be an excellent choice to provide some oversight or leadership. This group can design their own projects as a part of the 2008 strategic plan for the region*	**Chris Mehl is taking the lead on getting this sub-committee organized and plans to discuss with Dwight Thompson for follow-up in December**
	<u>Quality Improvement</u>: This Subcommittee developed its internal procedures and charters but has struggled to complete its tasks. It is suggested that the trauma surgeons at each facility participate in the review of transfer charts in the case of requests or deaths and that that activity will be recognized as having trauma CME value. J Hansen also suggests that the state registry compilation for the region be used to identify specific entities for action for this committee.	*Dr. Peden wants to stay on this committee and agrees with J Hansen*	**P Clifton and B VonBergen to bring this opportunity to the attention of the trauma surgeons who have CME requirements for verification and credentialing.**

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ADJOURNMENT	All business completed and meeting adjourned at 1730		
NEXT MEETING	Next ERTAC is sponsored at Billings Clinic on December 13th, 1530-1730 unless otherwise announced. 2008 dates: 2nd Thursday of the month March, June, September, December	Contact your telemedicine bridge operators to make the link and reserve the room.	
CONTACTS	SVH Trauma Coordinator: Penny Clifton 406-237-4292 BC Trauma Coordinator Brad VonBergen 406-435-1581 SVH Trauma Med Dir. Dennis Maier, MD 406-238-6470 BC Trauma Med. Dir. Robert Hurd, MD - Education Sub Com. Elaine Schuchard 406-228-8408 ERTAC Chair Kirby Peden, MD SVH OrthoTrauma Sally Hageman 406-237-4171 Trauma System Manager Kim Todd 406-444-4459 Nurse Consultant Jennie Nemec 406-444-0752	penny.clifton@svh-mt.org bvonbergen@billingsclinic.org rhurd@billingsclinic.org eschuchard@montanahealthnetwork.com kpedenmd@yahoo.com sally.hageman@svh-mt.org kimtodd@mt.gov jnemec@mt.gov	

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IMPORTANT DATES 2008	
STCC	February 11th (Helena)
Registry Meeting	February 12th (Helena)
ATLS	Feb 29th/ March 1st (Great Falls)
ERTAC	March 13th
ATLS	April 11-12 (Billings)
Spring Fever Trauma Conference	April 19th (Missoula)
STCC	May 12th (Helena)
ATLS	June 6-7 (Missoula)
STCC	August 11th (Helena)
Montana Trauma Systems Conference	Sept 10 (Missoula)
RMRTS	Sept. 11-12 (Missoula)
ERTAC	Sept 18th
ATLS	Nov 7-8 (Billings)
STCC	Sept. 17th (Helena)
ERTAC	Dec. 11th